Working with Immigrant and Refugee Populations: Issues and Hmong Case Study

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Abstract

There is a critical need to provide culturally and linguistically appropriate health information for immigrant and refugee populations. This article discusses the challenges related to providing health information for immigrants and refugees in the context of developing health education/health literacy programs. It includes lessons learned from National Library of Medicine (NLM)–funded health information programs in Wisconsin, particularly the Hmong health projects funded by the NLM Specialized Information Services Division. Topics include special needs of immigrant and refugee populations; health care for immigrants and refugees; identifying and working with partner organizations; examples of successful efforts; and finding funding sources for health information literacy projects.

For immigrants and refugees, finding useful health information is just one piece of the huge task of adapting and surviving in a new country. We need to "walk in their shoes" and listen to their stories before rushing into solutions based on our personal worldview of libraries and the World Wide Web as free sources of knowledge on a wide variety of topics, including health and disease. While we know that we need to take the time to learn about cultures other than our own, there is an immediate need to provide culturally and linguistically appropriate health information for immigrant populations. National standards require that most health care providers provide culturally and linguistically appropriate patient information. Those

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providing this health information and education are often frustrated in their search for appropriate resources. This is particularly true when working with refugees who have had minimal exposure to Western culture and health care systems.

This article will discuss issues related to health information for immigrants and refugees in the context of developing health education/health literacy programs for these underserved populations. When working with these populations, providing access to information via libraries and the Web is not enough—we need to work with consumer and patient educators to develop appropriate resources and programs that meet their information needs. The challenges involved will be illustrated with examples from National Library of Medicine (NLM)–funded outreach programs in Wisconsin. The focus will be on lessons learned from the Hmong Health Information Promotion (2001–2003) and the Hmong Health Education Network (2003–2004), both funded by contracts from the NLM Specialized Information Services Division. These Hmong health projects are partnerships managed by the Northern Wisconsin Area Health Education Center (NAHEC). The needs assessment process used to develop these projects is applicable to many populations. For more on needs assessment, review the community analysis advice offered in Consumer Health Information for Public Librarians (Baker & Manbeck, 2002).

The following topics will be addressed:

- Special needs of immigrant and refugee populations
- Health care for immigrants and refugees
- Identifying and working with partner organizations
- Examples of successful efforts
- Funding sources for health information literacy projects

Learning about the first three of these topics is the basis for the needs assessment that is the foundation for any health literacy program designed for a specific population. For immigrants and refugees, this process takes most of us out of our "comfort zone." Unless we make the effort to reach out beyond serving those who come to our libraries, and also take advantage of cultural competency learning opportunities, we miss the opportunity to serve those in greatest need. In other words, we need to learn from interpersonal networking and educational programs as well as the literature. In "Walk in Their Shoes," the keynote to the National Network of Libraries of Medicine Greater Midwest Region (NN/LM, GMR) Outreach Symposium of 2003, Dr. Kathleen de la Peña McCook urged librarians to get involved in their communities (de la Peña McCook, 2003b). She used the example of sitting on a board looking at housing issues as her way of getting involved in the community. By networking with other organizations serving immigrants, librarians will come to recognize opportunities for health literacy partnerships. We need to contact local service agencies to find opportuni-

ties to work together on health literacy initiatives. For example, through networking with United Way, Dr. Suzanne Matthew, the Northern Wisconsin Area Health Education (NAHEC) director, learned of Wausau's Minority Interagency Group, which meets six times a year. Meetings include updates on various programs for minorities in Marathon County. While this group started some twenty years ago because of the Hmong refugees, the recent regional Hispanic population increase has expanded the group's focus.

Note that needs assessment and planning will continue as projects are implemented. By working *with* refugee and immigrant populations, you will continue to learn things about the culture and language that will change your perception of what works, so plans need to be flexible with room for changing methods and approaches. EthnoMed (www.ethnomed.org) is an excellent example of a librarian working with clinicians and educators to develop online resources to support culturally competent care and patient education for immigrants in the Seattle area. As Ellen Howard stated in her excellent NN/LM GMR Outreach Symposium presentation, "While we intended to develop EthnoMed in a systematic way, because of funding opportunities and the need for specific information, the growth and development of the site has been more opportunistic than systematic" (Howard, 2003). It is particularly important to address this issue when developing funding proposals for health literacy initiatives for immigrants and refugees. Timelines need to be as flexible as possible to achieve goals and objectives while maintaining the specificity required by grantors. Program implementation always seems to take longer than you think it should due to the complexity of the needs and cultural structures and the need to work with multiple partners to achieve goals. However, by working *with* populations instead of doing for them, the products—health education programs and information resources—will be more valuable for these groups.

Special Needs of Immigrant and Refugee Populations

As reflected in Mary Pipher's book title, our newest refugees and immigrants are in "The Middle of Everywhere" (Pipher, 2002). Actually, we are a nation of immigrants, with every generation dealing with a different mix of cultures with their own health practices and beliefs. While the backgrounds of Western European immigrants are closer to mainstream American culture, those from developing countries—particularly refugees—often are quite different from our personal experience. Legal immigration includes those admitted for humanitarian reasons (refugees, asylees). The numbers in this category declined substantially to approximately 27,000 in 2002 and 2003, although as many as 70,000 are authorized. Refugees are here because they must leave their homes, and the requirements for refugee status are very specific. An Urban Institute presentation to the National Association for Bilingual Education highlighted three U.S. immigration trends (Fix & Passel, 2003):

1. High sustained flows: More than 14 million immigrants entered the United States during the 1990s—more than any previous decade—and this trend continues into the twenty-first century. This is at the same time that the number admitted for humanitarian reasons declined. Immigrants account for 11 percent of the U.S. population and 25 percent of low-income workers. Children of immigrants represent 20 percent of all children and 25 percent of low-income children.
2. Growing geographic dispersal: Prior to 1995, 75 percent of the nation's immigrants lived in six states (California, Florida, Illinois, New Jersey, New York, and Texas). This declined to roughly 67 percent in the 1990s, and some twenty-two additional states are now defined as "high-growth." Even this list does not include states like Wisconsin, where communities like Wausau have seen huge increases in immigrant populations. Twenty-five percent of the Wausau School District enrollment is Southeast Asian, and small rural farm communities are seeing similar enrollment levels for Hispanic students.
3. Increase in undocumented immigration: The flow of undocumented immigrants to the United States more than doubled between the early and late 1990s. Like legal immigrants, they are far more dispersed than in the past. This places a particular burden on health care services, particularly for urgent care needs.

Who Are the Hmong?

Since the Hmong population is not represented in many states, we will begin with some background information. For additional information and photos, see "Hmong Health Information: Lessons Learned; Future Directions" as presented at the 2003 NN/LM GMR Outreach Symposium (Allen & Matthew, 2003). Hmong refugees represent members of a culture that has never enjoyed a home country. Hmong means "free people." Over the centuries, the Hmong migrated from northern China into Laos. In Laos they were an agrarian society living in the hills, maintaining a culture separate from the Laotian people. Many of those in Laos joined what they refer to as the "Secret War," working for the U.S. Central Intelligence Agency (CIA) before and during the Vietnam conflict. They fought for the United States in the jungles and the air, even serving as pilots. Histories of the era speak of their high intelligence and ability to learn to use technology. The Hmong fled Laos in 1975 following the Communist takeover. They do not support the Laotian government, and one faction continues to work toward regaining their home territory in Laos, which creates ongoing dissension within the Hmong community. During and after the war many escaped to Thailand and lived in United Nations refugee camps prior to resettlement in other countries. The U.S. government followed a policy of dispersal, allowing no more than eight family members to emigrate as a group (Cha, 2003). This placed the Hmong and other new immigrants in smaller com-

munities that were not at all diverse. These dispersal policies were contrary to the cultural values of the Hmong, who emphasize family and clan affiliations—support systems that could have helped the Hmong deal with many of the adjustment difficulties that followed. Another consequence of these dispersal policies was a high level of secondary immigration, where many Hmong moved to be with their extended families. Many left California for communities like Wausau, Wisconsin, and Minneapolis/St. Paul, Minnesota, where education, health, and social services were perceived as more responsive to their needs.

Thailand never welcomed the Hmong as permanent residents. In the 1990s the official United Nations refugee camps were closed, with the Hmong expected to return to Laos or emigrate to other countries. Some were not ready to leave. Wat Tham Krabok, a Buddhist monastery, opened its gates to Hmong refugees. Approximately 15,000 live there in tin huts, forming four "villages." Their income comes from producing embroidery, clothing, and other traditional items for export. They have little education and no English language instruction. Some 45,000 remaining in Thailand outside Wat Tham Krabok can obtain an official government identification, but they can not work legally. By not emigrating when the camps closed, they lost their refugee status.

There is new hope for those registered at Wat Tham Krabok. On December 18, 2003, the U.S. State Department announced that those living there would be admitted as refugees sometime in 2004, as Thailand wants to permanently close the settlement (Southeast Asia Resource Action Center, 2004). Those who choose to come to the United States will be processed for emigration to communities where they have sponsoring organizations, hopefully near others from their families or clans. Hmong with family and clan support will have the advantage of peer mentors, who have adjusted to life here to the best of their ability. With the changing political and health care environment, however, the mentors also need resources to support them in this new role. It must be noted that many Hmong in Thailand fear coming to the United States. They have heard stories of gangs and violence from Hmong visiting or returning to Thailand because life in the United States did not work for them (Magagnini, 2004). These fears are a major concern of Hmong mental health professionals.

Unfortunately, this new opportunity is not available to those living outside the camp. It is highly unlikely that the Hmong people will be reunited in a single geographic region. Instead, at the April 2002 Hmong National Development conference Dr. Pao Saykao of Australia shared a vision of the Hmong coming together as a "virtual nation" (Saykao, 2002, 2003). He continues to contribute to discussions in the Hmong Newsgroup (http://soc.culture.hmong), working to achieve his goal of a caring Hmong culture that uses Internet communication to achieve its goals. As Detlefsen indicates in this issue, the Internet can be a tool for providing

virtual health information support systems for special populations like the Hmong (see 283–300).

Understanding reasons why immigrant groups are in your community and their vision for maintaining their culture is the first step toward developing working partnerships. The next step is to look at the information and health needs of immigrants and refugees in your community. These fall into four categories: language and literacy; health beliefs and health literacy; immigrant and refugee health issues; and the unique stressors related to refugee status.

Language and Literacy

Most immigrants and refugees arrive without English speaking abilities, let alone the ability to read and write—a major requirement for most definitions of literacy. Many come to America because of the limited opportunities for education in their home countries; they are looking for more opportunity in the United States. Furthermore, many refugees come from situations where societal structures were interrupted by conflict and war. Oral traditions may predominate. For example, the Hmong did not have a written language until the 1950s, and educational opportunities were extremely limited. They do have a strong oral history tradition, and they have used the traditional story cloth as a way of remembering their history (Cha, 1996). The culture is known throughout Southeast Asia for their embroidery "flower cloth," known as *pa'ndau* (pan dow).

Translation and interpretation can be a challenge, especially when dealing with multiple dialects and the relative lack of medical terminology. The National Council on Interpreting in Health Care (NCIHC) (http://www.ncihc.org) is an excellent resource for background on translation and interpretation issues in health care, including examples of typical problems related to inappropriate interpretation.

The Hmong language offers unique challenges that illustrate these issues. It has two main dialects—White Hmong and Green Hmong—with most agreeing that White Hmong can be read by all. When matching words do not exist—a common occurrence for medical terminology—the usual practice is to use several Hmong words that convey the concept. For example, the translation for "gout" is "crazy painful hand and foot." Still, Hmong-speaking professionals often disagree on the appropriate translation. In addition, some words are not considered appropriate to translate, particularly those related to sexual intercourse—a major problem when translating the script for an STD prevention video. Some Hmong are reluctant to use common translations that perpetuate stereotypes (Scott, 2003). For example, one colleague does not want the responsibility for translating "disability," as the commonly used words suggests that those with a disability are crazy. When translating health-related documents, it

is important to follow approved standards and require an independent reverse translation from the second language back to the first to be sure that the original meaning is not lost.

Because the Hmong population has limited reading skills, many wonder about the wisdom of translating written documents. Hmong health care providers prefer individualized face-to-face health education. There is a strong preference for audiovisual media that can be used in most Hmong households—many do not own CD or DVD players. A wide variety of audio and video cassettes have been produced since the Hmong began arriving in the United States. Many have a local focus or are direct translations of English productions that were not culturally appropriate. Some are too locally focused for general use, as they promote use of health care providers in a particular locale.

There is a small group of high-quality videos that are appropriate for Hmong-speaking audiences. Unfortunately, many of these are no longer available, while others contain out-of-date information. In 2003 our Hmong colleagues felt that audio and videocassettes were still the best options for health education. We are evaluating multimedia that can be delivered via the Web as a new option for cost-effective health education resources.

In July 2003 NLM hosted a conference sponsored by the Center for Public Service Communications, funded by the U.S. Office of Minority Health (OMH), the Robert Wood Johnson Foundation, and the U.S. Office of Global Health Affairs, titled "Symposium on Culturally and Linguistically Appropriate Health Information for Refugees and Immigrants" (Scott, 2003). A major impetus for this conference was the OMH release of national standards for culturally and linguistically appropriate services in health care in December 2000, commonly known as the CLAS standards (*Assuring Cultural Competence in Health Care,* 2000). The U.S. Office of Civil Rights Web site links to various federal regulations related to persons with limited English proficiency (LEP) (*Limited English Proficiency,* 2003). Reviewing and understanding these standards is critical for anyone developing health information programs for people with limited English proficiency. They are available online (http://www.omhrc.gov/clas), including HTML and PDF versions, along with background documents. The fourteen standards are organized by three themes: Culturally Competent Care; Language Access Services; and Organizational Supports for Cultural Competence. Language Access Services are *mandatory.* These standards are quoted below, with selected background and part of the explanation for Standard 7 (*National Standards for Culturally and Linguistically Appropriate Services in Health Care,* 2000). Reading the entire document is advised.

> Standards 4, 5, 6, and 7 are based on Title VI of the Civil Rights Act of 1964 (Title VI) with respect to services for limited English proficient (LEP) individuals.

> 4. Health Care Organizations Must Offer and Provide Language Assistance Services, Including Bilingual Staff and Interpreter Services, at No Cost to Each Patient/Consumer With Limited English Proficiency at All Points of Contact, in a Timely Manner During All Hours of Operation.
>
> 5. Health Care Organizations Must Provide to Patients/Consumers in Their Preferred Language Both Verbal Offers and Written Notices Informing Them of Their Right To Receive Language Assistance Services.
>
> 7. Health Care Organizations Must Assure the Competence of Language Assistance Provided to Limited English Proficient Patients/Consumers by Interpreters and Bilingual Staff. Family and Friends Should Not Be Used To Provide Interpretation Services (Except on Request by the Patient/Consumer).
>
> 8. Health Care Organizations Must Make Available Easily Understood Patient-Related Materials and Post Signage in the Languages of the Commonly Encountered Groups and/or Groups Represented in the Service Area.
>
> Materials in commonly encountered languages should be responsive to the cultures as well as the levels of literacy of patients/consumers. Organizations should provide notice of the availability of oral translation of written materials to LEP individuals who cannot read or who speak nonwritten languages.

Symposium participants broke into four discussion groups to review needs and propose recommendations. The similarity in the groups' recommendations was remarkable. All noted the need for national standards for culturally and linguistically appropriate health information, a central database of health information resources in all languages and formats (not just Web-based resources), and advocacy with public and private organizations that fund health information resources for the global village.

For more on the importance of appropriate language services for those with limited English proficiency, the NCIHC Web site (http://www.ncihc.org/hot.htm) includes links to federal and state regulations. NCIHC also links to other standards such as those from the Joint Commission on Accreditation of Health Care Organizations (JCAHO) related to non-English-speaking patients.

Many immigrants and refugees want to learn English, and English-speaking health providers want to know what translated documents say. For this reason, we have chosen to make our Hmong Health Web site and the resources we create bilingual. We model our resources on the two-column *English-Hmong Anatomy & Medical Phrase Book* (Lor, 1995), which was created for English as a Second Language (ESL) programs as well as Hmong families and their health providers. Bilingual resources are particularly helpful for those younger Hmong with less extensive knowledge of the Hmong language. While they may know everyday words spoken at home

and be able to read the written language, they have limited ability to translate or interpret medical terminology. EthnoMed is adding some excellent examples of bilingual health information in various languages, as well as audio and multimedia materials. Recent additions include bilingual cancer handouts in Asian languages (*Asian American Network for Cancer Awareness, Research and Training [AANCART] Translated Documents,* 2002; *Mammograms [Chinese],* 2004; *Mammograms [Vietnamese],* 2004). For languages that do not use the Roman alphabet, PDF files are the only logical choice; PDF is also best for items intended for printing.

Remember that these are generalizations—there is wide variation in every culture. For example, many of the Hmong that we work with speak and read multiple languages in addition to Hmong, including French, Laotian, and Vietnamese. There are Hmong elders who read Hmong, even though they have limited English ability. Many have an extensive knowledge of traditional healing practices, passed on via a long oral and visual tradition.

Health Beliefs and Health Literacy

Most immigrants come from places with differing health beliefs and health care systems. For example, in the traditional Hmong culture, those who are ill will consult a shaman, herbalist, or traditional healer. Knowledge of Western health care traditions is limited to those with exposure to missionary health programs and health services provided in refugee camps. They arrive with no knowledge of our health care system. ESL programs are introducing health literacy in their programs to help immigrants use the U.S. health care system. As so well-stated in its introduction,

> The Virginia Adult Education Health Literacy Toolkit grew from many teachers' observations of adult literacy learners whose education paused or ended because a small health problem became bigger and brought on a host of other difficulties. Many adult learners, particularly those with the lowest literacy skills, are unaware of accessible health care options for the un- and underinsured and have a limited understanding of prevention of those conditions for which they are at increased risk. Those who are able to access care often do not know how to advocate for themselves in the complex, changing U.S. health care system. The spoken and written language of the U.S. health care culture seems to them beyond their reach. (Singleton, 2003b)

Picture Stories for Adult ESL Health Literacy illustrates some common situations where increased health literacy is critical (Singleton, 2003a). Topics include Emergency; A Doctor's Appointment; Stressed Out!; What Should She Do? (Domestic abuse); Depressed; The Right Dose; What Happened to My Body?; and Snack Attack. Other resources for adult ESL programs are linked from the National Center for ESL Literacy Education (NCLE) Web site (http://www.cal.org/ncle), which includes a section of health literacy resources. The National Institute for Literacy (http://www.nifl.gov) is a good starting place for literacy information.

Differing health beliefs are a barrier to patient-provider interactions, especially when providers and interpreters do not know about or respect traditional healing practices. As we developed the Hmong Health site, we were particularly interested in making the site a tool for patient-provider interaction. The site includes a Traditional Healing section, with plans for adding information on Hmong herbs. Photographs of herbs will be posted with brief English and Hmong descriptions so that the Hmong will be able to tell their providers which herbs they are using.

Cultural beliefs about death and dying also affect provider-patient communications; Dr. Saykao believes that this is one of the most important things for providers to learn about another culture. His *Hmong FAQ: Death & Dying* summarizes these beliefs for providers (Saykao, n.d. a).

Immigrant and Refugee Health Issues

Speakers at the July 2003 Symposium at NLM summarized the health issues faced by immigrants and refugees. Since the final report is not widely available, excerpts are quoted below with permission:

> Before entering the U.S., all Refugees and Immigrants receive a health examination to identify potentially excludable medical conditions, such as active TB, HIV/AIDS, other sexually transmitted diseases, and mental health conditions that pose a danger to themselves and others.
>
> Recently, people from foreign countries arrived from Severe Acute Respiratory Syndrome (SARS)–infected areas. It was essential to communicate with them about health matters to protect their health and the health of Americans.
>
> Many of these immigrants have significant health problems—over 70% of California refugees had at least one significant health problem and 98–99% of Massachusetts had physical and mental conditions, which required a follow-up after assessment, when entering the U.S. Furthermore, as explained by David Smith [U.S. Office of Global Health Affairs], the longer foreign-born immigrants are in the U.S. the worse their health. To compound the problem, low-income immigrants are twice as likely to be uninsured as other low-income citizens. (Scott, 2003, p. 5).

The comments on worsening health status are particularly worrisome. Surveys and screening at Hmong health promotion events indicate a high incidence of hypertension, diabetes, and kidney stones, particularly among the elderly who have little or no English skills. Locally, the Wausau SCHOOL Project found that 39.5 percent of Southeast Asian children had 2 or more risk factors for cardiovascular disease, compared to 27.2 percent of Caucasians (Grady et al., 2003). Health providers are alarmed at the increasing incidence of heart disease, stroke, and obesity.

Groups such as Hispanic migrant workers face additional health issues related to seasonal migration. One of the goals of the rural Southwest Wisconsin Health Information Access Project (2001–2004) was to provide culturally sensitive and linguistically appropriate consumer health informa-

tion to minority groups, including Hispanic migrant workers. Working with the bilingual health educator at Family Health/La Clinica in Wautoma, Wisconsin, increased our understanding of migrant health issues. Their Mobile Medical Unit visits migrant camps from July through August, often providing the only health care these migrants receive. As part of the unit staff, the bilingual Southwest Wisconsin Area Health Education Center (SWAHEC) library intern had the opportunity to observe migrant life. Given the poor housing and food services, it was not surprising that many migrants had problems following through on the recommendations for diet and medications needed to deal with chronic conditions. Providing bilingual health education materials is not enough to overcome health disparities.

Stressors Related to Refugee Status

In addition to diseases endemic in developing countries, many refugees suffer from post-traumatic stress disorder. This affects all surviving a conflict—not just those who were actual combatants. Losing family members and living through the jungle and guerilla conflicts are equally stressful. Many have been raped; others have survived torture or long journeys with minimal sustenance. Those that make it to the United States are the survivors, but they still have unresolved mental health issues. However, many cultures are not accustomed to Western approaches to mental health (Cha, 2003; Pipher, 2002). Instead, the common practice may be to resolve problems within the family and clan or consult a traditional healer. Psychotherapy that involves discussing these issues outside the clan may be simply unacceptable. On the other hand, accessing Western mental health services is essential when these refugees need to qualify for disability benefits and services. For more resources addressing the needs of refugees and survivors of torture, see Plumb's overview and resources for nurses (Plumb, 2003).

Health Care for Immigrants and Refugees

Public health is responsible for initial health exams. Immigrants then face the same health care access issues as the rest of our society, which are compounded by the problems of language barriers and low-income status. As Plumb notes, "their poverty, when combined with other factors, sets them apart from even the poorest patients a nurse is likely to encounter" (Plumb, 2003, p. 98). Those who become employed will receive any health benefits offered by their employer. Those who qualify for welfare programs can use the health benefits that come with this assistance—provisions vary from state to state. Many states offer health insurance to low-income families with children, but this is usually not an option for those without children. The free clinics and community health centers described in the next section on partner organizations are often the only option for continuing care. Due to this lack of access, immigrants (along with huge numbers of uninsured

Americans) may not use clinics for routine care. Instead, they wait until health problems become emergencies and head to the emergency room, which must serve them regardless of their ability to pay. The complex U.S. health care system is a critical piece of health information that needs to be explained on a state-by-state basis. A Minnesota handbook (Minnesota Department of Health, 1998) is just one example of attempts to communicate this vital information. It has been translated into Hmong, Somali, and Vietnamese. We have permission to adapt it as part of a family health guide for the Hmong in Wisconsin and elsewhere.

Interpreters serve a vital role within the health care system. As noted, the CLAS standards *require* health providers to provide appropriate language services. The National Council on Interpreting in Health Care (NCIHS) is a multidisciplinary organization whose mission is to promote culturally competent professional health care interpreting as a means to support equal access to health care for individuals with limited English proficiency (http://www.ncihc.org/). NCIHS offers a series of working papers exploring the issues involved in interpreter services. While there is a lack of consensus on requirements for interpreter training, there is general agreement that it should cover standards for the interpreting process as well as background on medical terminology and the health care system. Interpreters need to know the most accepted words for medical terms in the language and dialects used by their patients. It is not enough to be bilingual in everyday conversation. While those teaching interpreters in English may be able to assess student competence in the process of interpreting and their knowledge of appropriate behavior, they cannot assess the student's command of the non-English languages unless they are also fluent in those languages. There is a tremendous need to train qualified interpreters as well as bilingual staff for health organizations. Interpreters are expected to provide direct translations of what is said and *not* act as cultural brokers. It is not appropriate for them to decide what to tell patients and family members and what information to withhold, even when the values of their culture conflict with what the provider says. For example, many cultures do not believe that one should tell a patient that their condition is terminal. Instead of telling patients that they will die if they do not follow through with treatment, it is better to say something like "If you do this, you will live long and be happy." Because of communication problems related to culture, providers may need to work with a cultural broker as well as an interpreter. The case studies in *Healing by Heart* (Culhane-Pera, Vawter, Xiong, Babbitt, & Solberg, 2003) provide moving examples of situations where providers tried to resolve difficult situations, sometimes involving a cultural broker. This work offers a "Model for Culturally Responsive Health Care" that can be applied to any culture, not just the Hmong.

Identifying and Working with Partner Organizations

Librarians must develop partnerships with a wide variety of community organizations to support health literacy initiatives. If you are involved in local 2–1–1 efforts, this task will be much easier—this was a key recommendation from Dr. McCook in her NN/LM GMR Outreach Symposium keynote (de la Peña McCook, 2003b) The *Pass 2–1–1* Web site for 2–1–1 background information is http://www.211.org. To learn more, read "2–1–1 Helps Connect People and Services" (Ray, 2003) . 2–1–1 initiatives are jointly sponsored by the United Way of America, AIRS(The Alliance of Information & Referral Systems) and other organizations interested in information and referral services. Contact your local information referral service for information on the nonprofit organizations and other organizations in your community that work with immigrants and refugees. This will include a wide variety of voluntary community agencies (volags), such as Catholic Charities and Lutheran Social Services. These two organizations are among those that officially sponsor refugees and help them when they first arrive in the United States. Volags also include population-specific groups such as the Hmong mutual assistance associations.

Successful networking extends beyond local organizations. You can learn about successful partnerships around the country by keeping your eyes open for examples and potential partnerships. Dr. McCook manages A Librarian at Every Table (ALAET), a mailing list that announces resources for community building (de la Peña McCook, 2003a). The archived list is a treasure trove of information on exciting community initiatives. Recently, the NN/LM MidContinental Region announced the launch of "Bringing Health Information to the Community" blog at http://medstat.med.utah.edu/blogs/BHIC. Information posted on this blog includes conferences, grants, articles, minority health concerns, rural health concerns, and more that would be of interest to community-based organizations that include health as part of their outreach. You can subscribe to regular email updates.

Potential Partners

Area Health Education Centers (AHECs) are one good place to start. The AHEC mission is to "To enhance access to quality health care, particularly primary and preventive care, by improving the supply and distribution of health care professionals through community/academic educational partnerships" (*NAO: National AHEC Organization,* 2004). One of the four AHEC program areas is to "Promote improved health and increased disease prevention in a manner that responds to defined community needs, with emphasis on underserved areas and populations having demonstrated serious unmet health care needs" (*NAO: National AHEC Organization,* 2004). Health education and health literacy efforts are a natural fit for AHECs, as well as the national Health Education Training Center programs affiliated

with AHEC (*National HETC Health Education Center Training Centers,* 2003). While AHECs are started with federal funds, most are funded from a variety of sources including federal and state budgets, grants, and program income. Many AHEC centers sponsor cultural diversity training. In Wisconsin this has included the *Wisconsin Express* for health professions students and continuing education for health and social services professionals. When NAHEC submitted the first Hmong health proposal to NLM, they were able to include an extensive list of prior cultural diversity initiatives to help justify organizational competence to manage this program. For more information about Area Health Education Centers (AHECs) in general, see the National AHEC Organization (NAO) Web site (http://www.nationalahec.org/main/index.asp).

State and local health departments are key partners, as well as a source of information about other community partners. Health departments are usually responsible for the initial health screening and for ongoing management of chronic communicable diseases, such as programs for Hepatitis C and tuberculosis carriers.

Other potential health care partners include hospitals, clinics, managed care programs, and local branches of organizations like the American Cancer Society. All have an interest in improving service to minorities in their community. When working with health organizations, try to identify nurses, health educators, or others with a significant interest in and accountability for patient/consumer health education resources. Jan Kraus, the volunteer Hmong Health Webmaster, is the Wausau Hospital librarian. She is committed to the project because she saw the Hmong population as a significant part of the community served by the hospital. As a teaching clinic with a Hmong nurse, the University of Wisconsin Wausau Family Practice Clinic was already committed to outreach to the Hmong community. MeLee Thao, R.N., has provided medical content expertise as well as cultural guidance.

Your community may also have free clinics and/or community health centers that provide care to the un- and underinsured. Federally Qualified Health Centers receive funding to provide medical and dental care to underserved populations—see the Bureau of Primary Health Care Web site (http://bphc.hrsa.gov) for background on various types of health centers. The National Association of Community Health Centers (http://www.nachc.com) has links to state associations listing or linking to local health centers that are part of this network.

Managed care programs are interested in health promotion activities to minority populations included in their programs and may have staff representing these populations. Representatives from managed care programs are very active in Minnesota's Hmong Health Care Professionals Coalition, and they have been instrumental in getting their employers to help fund coalition activities like the annual health fair. Nonprofits like the American

Heart Association and the American Cancer Society are particularly interested in outreach programs related to their mission. They may have funds available to develop needed foreign language information resources or be willing to offer translation permission.

Other potential partners include public and hospital libraries and academic institutions. For public libraries, start with the director and try to identify those responsible for outreach and literacy activities, as well as any bilingual staff from the target population. For academic institutions, look at three groups: health professions programs, extension/outreach departments, and diversity initiatives. The latter may include student groups, such as the Hmong and South East Asian American Club (HaSEAAC) at the University of Wisconsin–Stevens Point (UWSP). This group offers cultural education programs and is a key resource for recruiting students to work on the Hmong health projects. Faculty from academic programs can help identify potential student interns and recruit others for community service projects, such as screening at health promotion events.

ESL programs are also key partners, as suggested by the discussion of literacy above. They may be sponsored by community colleges, local schools, libraries, or voluntary agencies. Check to see who is responsible in your community, and follow up with information on health literacy resources that they can include in their classes. Health literacy is a relatively new movement within the ESL community, and many are uncomfortable with the content. In addition to resources, they may welcome health professionals as guest instructors. Many ESL programs are also addressing computer and general information literacy—librarians may want to start by helping with the basics of information literacy as the prelude to introducing health literacy content.

As you identify potential partners, the next step is to contact them and discuss local needs and initiatives, as well as common interests and concerns. When developing the Hmong Health Information Promotion project, we had just a few weeks to respond to the call for proposals, so many of these contacts were via phone and follow-up email. Phone interviews with public health nurses and school programs were particularly helpful, with public health nurses serving as the key informants on local health information needs. The school's ESL program coordinator provided useful statistics demonstrating the high percentage of Southeast Asian students in the Wausau school district. Phone calls are not enough, however, particularly for groups representing the local immigrant population. In many cases, personal meetings will be most useful. By meeting with the executive director of the local Hmong association, we learned their views on the need for health information and translation issues particular to the Hmong population and gained support for the proposed program. Since then, they have hosted all meetings of the Hmong Health Steering Committee and worked with us on each of our project teams. The Hmong health projects

have used these quarterly steering committee meetings as a way of bringing partners together to discuss Hmong health information needs and the project activities. The group has helped evaluate our progress and serves as a source of volunteers for project teams. Individual meetings with funded partners continue to serve as a source of guidance and direction. Those that have limited funding for health education outreach need financial support in order to commit significant staff time to project activities. Our budgets include funding for work by other agencies, such as translations and content development.

Examples of Successful Efforts

In addition to health literacy issues, immigrants and refugees are not familiar with library services. Psychologist Mary Pipher includes taking immigrants to the public library in her list of cultural brokering activities (Pipher, 2002). While parents may not know about information access opportunities, children are learning about computers, the Internet, and libraries as part of their American education. When planning the Hmong health projects, we were told that many Hmong homes had computers for their children but that home Internet access was not common. Many of these computers are secondhand models, lacking high-end features. Thus, providing library collections and bilingual Web sites is not enough. Health literacy programs need to include health promotion, education, and screening by health professionals or students. The projects that follow represent "successes" as well as lessons learned. These summaries note how librarians helped with organization and communication, as well as training and technical support.

Health Education Events

Health fairs offer a means of promoting health education resources, including those available from libraries and the World Wide Web. They can include health screening, as well as health education on selected topics. Attendance is better when offered in conjunction with another event, such as the Hmong soccer/sports tournaments hosted by Hmong associations around the United States. My Shoua Vang, R.N., reports an annual attendance of 300 during the Sheboygan, Wisconsin, soccer tournament. She notes that location and timing are keys to success—schedule for a short time during morning hours. The best site is next to the food stands. Funding for their health education program comes from an Office of Minority Health grant (*Sheboygan Bilingual/Bicultural Healthcare Project,* 2003).

The Hmong Health Care Professionals Coalition in Minnesota (http://www.co.ramsey.mn.us/PH/hi/hmong_coal.asp) has sponsored nine health fairs at the annual July 4th Lao Family Hmong Sports Tournament, which draws some 30,000 Hmong from several states. This group meets monthly, including an annual planning retreat. An annual theme is selected for each

health fair: diabetes and hypertension for 2002; kidney disease for 2003; and chronic diseases—cancer, cardiovascular disease, and diabetes—for 2004. A brief news item describing the 2004 health fair is available on the Hmong Health Web site at http://www.hmonghealth.org/news/articles.asp?ID-19, linking to a PowerPoint presentation with photos of the event. Attendees go through screening and education stations in the health fair tent, concluding with education by Hmong physicians for those with questions or health concerns related to the education and screening results. At the end, they are asked to respond to a survey/evaluation and are given "incentives," seen as vital to promoting visits to the health fair tent. The incentives include taking their picture with a Polaroid camera and placing it in a magnetic picture frame with health tips on the border. They also include bags stuffed with promotional items from sponsors, ranging from pens, key chains, and pill boxes to small boxes of cereal and individual bottles of water. The latter reinforced the "drink plenty of water" lesson for kidney disease. In 2002 this health fair included an exhibit featuring our Hmong Health Information Promotion project. For the past three years, the NN/LM GMR supplied MEDLINEplus pens and bookmarks for the bags and NLM was listed as a sponsor. We included Hmong Health bookmarks and saw an increased use of the site following the 2002 event. The bags also included Hmong language literature from the Minneapolis Public Library, which maintains a Hmong language Internet start site for their library. Our project helped provide volunteers for this event, who assisted with registration, education, and incentives.

Following the annual health fair, the coalition hosts a celebration lunch, complete with a program and a buffet of traditional Hmong foods. Coalition volunteers invite their supervisors and coworkers to thank them for their support and let them know more about Hmong health education needs. For the past three years, our project coordinator has prepared a PowerPoint presentation with photos of the volunteer activities, as well as summaries of the participant surveys.

Exhibits are another way to promote your efforts. We exhibited at the 2002 Hmong National Development conference in Milwaukee, featuring the new Hmong Health Web site as well as Healthy Wisconsin People and the Wisconsin AHEC Health Careers initiative. The health careers information was of particular interest to the many Hmong students in attendance, which is important to the goal of achieving a bilingual health care workforce. Attendance was not as good at a Hmong Resource Fair held on a Saturday in May 2002 at a St. Paul high school—there seemed to be more exhibitors than attendees. However, it was a great opportunity to collect a wide variety of information resources for potential listing on our Web site and to network with others interested in information resources.

Health education programs for immigrants require extensive planning and coordination. Scheduling, incentives, transportation, and child care

Picture frame used with Polaroid photos of Hmong Health Fair attendees, an incentive to encourage attendance.

all need to be considered. NAHEC librarian Diana Robertson chaired the planning team for the fall 2002 Hmong Women's Health Conference held in Wausau. Team members included Hmong staff from public health, the public library, and the Hmong association, as well as representatives from the local Family Resource Center, the Family Planning Health Promotion Center, Hmong student interns, and NAHEC project staff. The students helped develop a bilingual brochure, which was mailed using the Hmong association mailing list and distributed at Hmong grocery stores and the Hmong association. The event was hosted by the Family Resource Center, with their Hmong staff handling phone registrations and providing child care. There was a keynote in Hmong by a Hmong social worker. Participants could attend two of four breakout sessions, either in Hmong or interpret-

ed. Those given in English—breast cancer and family planning—featured Hmong language videos. The mental health and sexually transmitted disease sessions were in Hmong. Exhibits included health topics such as breast feeding, nutrition (WIC), and tobacco control, as well as blood pressure screening. The public library had an exhibit featuring library resources, and our project had an exhibit featuring health information on the Web. Hmong food was served at the break, and all attendees received donated door prizes. Unfortunately, the official attendance was just nineteen women, with at least as many children. While scheduled on a Saturday morning, seen as the best time for this audience, the date ended up conflicting with the annual ginseng harvest. In general, Saturday events will not work whenever gardening and other outdoor activities compete for attention. The planning team agreed that any future Hmong health events need to be scheduled in early spring, or in conjunction with other programs and events. We are considering a health fair as part of the Wausau-area Hmong New Year celebration held annually in November. We are also looking at ways to offer health education to various Hmong groups by integrating it with local educational programming.

As this article goes to press, the Wausau Area Hmong Mutual Association (WAHMA) is assuming the leadership role for developing community-based Hmong health education programs in the Wausau area. They received a Wisconsin Office of Minority Health mini-grant to offer Hmong health education in the Wausau area, which included a very successful Saturday Hmong Health Fair with Hmong language workshops and four weekly follow-up sessions. The key to success was health education in Hmong, the primary language for this population, with marketing by the Hmong community. Lessons learned are helping to develop a strong funding proposal. We believe that the Hmong Health Educations Network will continue as an exemplary program, with local librarians as partners in healthy literacy programs to promote health for all populations.

Another venue to explore is Hmong radio and television programming. In Minnesota Mao Thao and Kev Koom Siab have collaborated to present the weekly "Health Talk" program (*Hmong Television Program—Health Issues,* 2002). Short audio and video programs could be featured on non-English radio and television programs on stations around the country.

Provider Training

In Wisconsin AHEC health information access needs assessments told us that providers wanted help finding resources for consumer/patient education. This included the need for quality foreign language resources, including Hmong, Spanish, and Somali resources. For example, a public health nurse in rural Green Lake County noted the need for Hmong language resources in a community of 3,500 that has 600 Hmong. When immigrants are dispersed to rural areas, health provider organizations are simply too

small to produce their own resources in multiple languages. The Web offers a rich resource for those who learn how to quickly find what they need.

Provider training is the critical key to the success of consumer health literacy programs. Providers, educators, and librarians need to know what is available and how to find it quickly at the time of need. The consumer health training has been very popular. We have taught a wide range of professionals to search the Web for quality health information using the Healthy Wisconsin People Web site (www.healthywisconsin.org) as our gateway. It features three key resources—MedlinePlus, HealthFinder, and BadgerLink—as well as Hmong Health and other sites selected to meet the needs of Wisconsin residents. As part of the SWAHEC information access project, our bilingual intern selected and described several Spanish language health information resources, adding bilingual descriptions. Given the large number of Hispanic resources, there was no need to develop our own Spanish language site.

In addition to training, we have exhibited at various conferences for health professionals as part of our health information outreach efforts. In the spring of 2003 those attending the Wisconsin Student Nurses Association conference were particularly pleased to learn about the Hmong and Spanish information resources, as well as NLM resources and the Healthy Wisconsin People Web site.

Hmong Health Web Site

Lack of access to Hmong health information was identified as a critical need when planning the Hmong Health Information Promotion project. Dr. Pao Saykao uses blood testing as an example of the need for explaining procedures to Hmong patients (Saykao, n.d. b). The Hmong Health Web site (www.hmonghealth.org) was conceived as a gateway to Hmong health information resources, both on the Web and in other publication formats, particularly audio and video formats. We link to individual documents in Hmong and their English counterparts—not just to Web sites with Hmong resources. The goal is to provide access with a minimum of clicking. We face the usual problem of changing links, particularly at the specific document level.

While librarians provided the leadership for the Hmong Health Web site, participation by three Hmong team members was critical to the design. For example, original plans to use Hmong storycloth figures were rejected because they could be seen as representing particular clans, not the entire Hmong community. Instead, the Web site uses a border based on the traditional *pa'ndau* and photographs featuring Hmong people. The Traditional Healing section was added as a resource for health providers, who were not seen as part of the initial target audience. The bilingual format is based on preferences expressed by the Hmong community, which included placing English on the left, rather than Hmong. This is seen as supporting their

Hmong Health Web site home page.

goal of learning English. Active server page templates are used to maintain a consistent style that supports the bilingual format.

Library promotion and resource identification is a key feature. The Library Resources page features a basic "About Libraries" section written and translated by Tong Xiong, one of our Hmong students. It includes links for finding public libraries, including one to the local library Web

Hmong Health Web site Library Resources section, depicting the two-column bilingual format used throughout the site.

site, as well as links to other resource centers for information related to the Hmong. The rest of this section offers lists of published Hmong health resources by format, such as books and videos. These lists include titles and summaries, with links to individual bilingual records for each item. Our goal is to include Wisconsin library locations from WISCAT, the statewide union catalog, as well ordering information when available.

Other original content includes the information published in the *English-Hmong Anatomy & Medical Phrase Book* (Lor, 1995). We had to substitute original drawings for the anatomy section, as the commercial publisher that gave copyright permission for the first edition was sold to a larger publisher not interested in supporting this project.

Health Information Resource Development

Unfortunately, we could not find appropriate resources for meeting all the Hmong health information needs identified by our partners. As we looked for resources to translate, we found that many were not at an appropriate reading level. Most lacked visuals, and images of Asians were uncommon. Copyright is a continuing challenge; when we found something we wanted to translate, professional organizations were reluctant to authorize adaptation and translation. However, government organizations are very helpful. We received permission to translate hypertension and safe fishing information and to use and adapt the health guide for refugees in Minnesota (Minnesota Department of Health, 1998). The latter will become part of a loose-leaf *Hmong Family Health Guide* that will be both sold at cost and published via the Hmong Health Web site. This will update the 1995 *English-Hmong Anatomy & Medical Phrase Book.*

We determined that audiovisual health information resources were a high priority due to Hmong preferences for in-person learning opportunities and audiovisual media. This preference was confirmed by the 2002 University of Wisconsin Extension's statewide assessment of Hmong educational needs (University of Wisconsin–Extension, 2002). Our original intent was to produce Hmong language health education videos using health promotion interns as producers. We quickly learned that the cost of professional quality videos far exceeded our budget. Hmong and provider team members identified priorities for electronic content, with sexually transmitted disease (STD) prevention heading the list. Given limited funds, nurse practitioner Lynn Buhmann from Wausau Family Practice took the initiative to apply for a Wausau Community Health Foundation grant to support production costs. NAHEC agreed to use Hmong Health funds to support script translation and costs of reproducing CD and video copies of the final production. So far, more than 110 videos and close to 70 CD-ROM copies of *Kab Mob Kascees: Sexually Transmitted Diseases: How to Protect Yourself and Your Family* have been distributed to organizations in seventeen

states. Hmong and English scripts and evaluation forms are provided via the Hmong Health Web site.

Due to high video production costs and our desire to use the Internet to distribute future productions, we investigated options such as audio and video streaming, but we quickly determined that we did not have the required expertise. Our Hmong content advisor was particularly impressed with the Patient Education Institute's *Interactive Health Tutorials* (National Library of Medicine, 2004). There is a tremendous interest in this type of resource—the tutorials are one of the most popular features on MedlinePlus. EthnoMed was able to license and translate the interactive breast cancer module into Vietnamese (*Breast Cancer [Vietnamese],* 2003). Unfortunately, the reported cost was beyond our budget, especially when including the costs of translation and recording.

Networking can lead to new partners. A librarian shared our listserv announcement of the STD prevention video with Dr. Mary Alice Gillispie, producer of multimedia modules for the Healthy Roads Media project originally funded by an NLM Digital Libraries grant. This project features "free audio, written and multimedia health education materials in a number of languages. They are being developed to study the value of these formats in providing health information for diverse populations" (*Healthy Roads Media,* 2004). These multimedia programs are produced with Macromedia Director. Working with this format is very attractive, as the content can be downloaded by computers with slow connections and requires no Web plug-ins. It does not require the viewer to advance each slide, so that the delivery is smooth. As noted, print and audio versions are also available.

This librarian referral initiated a fruitful collaboration. With funding from our Hmong Health project, Dr. Gillispie adapted the English versions of the Healthways Software *Heart Health* series for the Healthy Roads Media Web site. We have permission to adapt and translate these modules for our Hmong audience. In addition, we are producing additional titles for the series that will cover "How the Heart Works" as well as heart attacks, heart failure, and strokes. Heart disease is increasing in the Hmong population, perhaps due to our poor Western diet, and is seen as the first priority for multimedia development. At the time of writing, English scripts were ready for final approval, and photo selection is in process. We plan to test the modules with Hmong audiences before publishing them to the Hmong Health Web site. Once the first series is complete, we plan to find funding for other topics.

The final report for the initial Healthy Roads Media NLM grant notes that librarians were very effective as trainers for the contacts at their project test sites (Gillispie, 2004). Patient acceptance was excellent. Enthusiasm varied at the performance sites, with best results at two sites where staff members took a personal interest in promoting the resources to their patients. Traffic has been steady since the Web site was opened to the public.

Hmong Health Education Network Development

Via the Hmong Health Web site and HmongHealth listserv, we are attempting to develop a virtual community for those interested in health education for the Hmong. The Web site and Internet mailing lists are used to announce conferences and new Hmong language video programs. A new "Contact us" form has opened communication with potential partners, leading us to more resources to include. We are exploring our future with the Hmong Health Steering Committee to find the best way to continue this initiative.

Funding Sources for Health Information Literacy Projects

Where does one go for funding projects like the Hmong health initiatives? The answer to this question depends on the scope and focus of your project. The key is to do a realistic needs assessment and then find organizations interested in funding the needs you have identified. Success depends on a close match between your needs and the goals of a foundation or government program. Think about the components of your proposal. If it focuses on health information for minorities, consider organizations interested in health information (NLM and NN/LM), health literacy (American Medical Association and Pfizer), or minorities (U.S. Office of Minority Health and Robert Wood Johnson Foundation). Note that the examples in parentheses represent just the tip of the iceberg. Both interpersonal and online networking can help identify potential funding sources. For additional general tips and Web links, see Peg Allen's grants page (http://www.pegallen.net/grants.htm).

Small pilot projects can be funded by a wide variety of organizations. Consider both federal and state health, education, and library programs. For example, Wisconsin libraries have included immigrant populations in their special needs grants that are part of the state's plan for federal Library Services and Technology Act (LSTA) funds. The NN/LM outreach awards and grants often give priority to special populations, such as immigrants and refugees. Nonprofit organizations will be interested in funding programs that focus on their area of interest. For example, the March of Dimes offers community awards for programs promoting healthy babies. Local banks and telecommunications companies have helped support our information literacy activities. Verizon funded a portable computer lab for NAHEC, as well as a computer lab for a local agency offering ESL training. As noted, the STD prevention video was funded by a local health foundation. It should be noted that $10,000 was the upper limit for these programs. AHEC centers may have small grant programs, such as the SWAHEC funding for the La Crosse County Health Department's *Eat Healthy and Be Physically Active for a Healthy Life* Hmong language video.

Success with small pilot projects should help establish your credibility

with those funding larger initiatives. It is a good idea to learn as much as possible about the art and science of grant writing. Attend educational offerings, and use your closest Foundation Center Library. When submitting a grant application, be sure to have it proofread and reviewed by others. Does it make sense to someone not involved in the detailed planning? Above all else, follow directions and meet deadlines! Competition is intense, and simple mistakes are all it takes to discount your application.

Conclusion

There is a tremendous need for effective health education and health literacy programs for immigrants and minorities. Librarians have the organizational, technical, and teaching skills needed to develop partnerships to meet the health information needs of consumers and their health providers. By working together with representative consumer and provider groups, we can provide practical solutions that help bridge the gap.

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